BOULDER VALLEY
Hearing Associates

BOULDER VALLEY
Ear, Nose & Throat

Provider: JDW/DDM/ACG/DAM MB/JL

Au.D.: GM/SD/KG/MC

New Update

PATIENT INFORMATION

_____ _____ _____
First Name *M.* *Last Name*

Sex: **M** **F** D.O.B. _____ AGE: _____ MARITAL STATUS: **S** **M** **D** **W**
MM/DD/YYYY

_____ _____ _____ _____ _____
Home Address: *APT#* *CITY* *STATE* *ZIP*

Hm Ph# _____ Wk Ph# _____ Cell# _____

Which number should we contact to leave a message? Home Work Cell

Employer _____ Email _____

REFERRING DOCTOR / PRIMARY CARE PHYSICIAN _____

Dr. Phone#_____ Preferred Pharmacy_____ _____
Pharmacy Ph#

PRIMARY INSURANCE COMPANY _____ (Please present you card)

Policy Holder _____ Relationship to Patient _____

D.O.B. _____ Employer_____ Ph # _____
MM/DD/YYYY

OTHER INSURANCE _____ (Please present you card)

Policy Holder _____ Relationship to Patient _____

D.O.B. _____ Employer _____ Ph # _____
MM/DD/YYYY

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Contact Name: _____ Relationship to Patient _____

_____ _____ _____ _____ _____
Home Address *Apt #* *City* *State* *Zip*

D.O.B. _____ Home Phone _____ Cell Phone _____
MM/DD/YYYY

BY SIGNING BELOW I AM ACKNOWLEDGING THAT THE ABOVE INFORMATION IS CORRECT AND THAT I HAVE READ AND UNDERSTOOD THE INFORMATION ON THE REVERSE SIDE OF THIS FORM. I AM ALSO AUTHORIZING THE BILLING OF THE ABOVE MENTIONED INSURANCE COMPANIES.

_____ _____
Patient or Guarantor Signature MM/DD/YYYY

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David D. Morrissey, M.D.
Andrew C. Goldman, M.D.
Myra B. Baker, PA-C
Jensen T. Lewis, PA-C

FINANCIAL POLICY

Please Note: *Complete insurance and personal information is required at the time of your visit in order for our office to file a claim to your insurance. If this information is not provided at the time of your visit, we require payment in full. In lieu of payment in full, we will hold a current credit card copy for 5 business days as a courtesy to you. If at the end of 5 days we have not received the missing information, your card will be charged any balance due at that time.*

Questions regarding your insurance coverage and benefits are best directed to, and answered by your insurance company.

CONTRACTED INSURANCE PLANS

- Boulder Valley Ear, Nose & Throat is contracted with most major HMO/PPO commercial insurance companies. Please call your insurance company to ensure we are in-network with your specific policy.

COPAYS/CO-INSURANCE/DEDUCTIBLES

- Copays specified by your plan (usually indicated on your insurance card), must be collected when you arrive for your appointment. Please be aware that Insurance companies instruct medical offices to reschedule appointments in the event a copay is not provided.
- Co-Insurance/Deductible: Should your plan include coinsurance and or deductible responsibilities. Boulder Valley Ear, Nose & Throat Assoc., reserve the right to collect resulting balances at the time of your service or prior to surgeries.

NON-CONTRACTED COMMERCIAL INSURANCE, TRAVEL INSURANCE, OUT OF COUNTRY INSURANCE

- In the absence of a contract, Boulder Valley Ear, Nose & Throat is unable to financially hold your insurance responsible for your visit. As a result, you will be responsible for paying any charges in full at the time of your visit. We will bill your insurance one time as a courtesy to you. You will receive any monies reimbursed by your insurance. Please note that you are responsible for the full balance.

MEDICARE

- We will file Medicare claims on your behalf. Please provide any supplemental insurance information to the front desk at the time of your service. Any remaining charges will be billed to your secondary insurance once processed by Medicare.

CHARGES

- Multiple and separate charges may be incurred during the course of your visit. Your provider may utilize various diagnostic instruments, order tests, or perform in-office surgical procedures in order to render appropriate medical care. Insurance companies define charges for a procedure involving the usage of diagnostic instruments as surgical. This will be reflected on the "Explanation of Benefits" you receive from your insurance company. ***If you have questions or concerns regarding a possible procedure and associated costs,*** please ask to speak with a representative in our billing department.

INJURY RELATED CLAIMS (Worker's Comp, Auto and Personal Injury)

- We will file the above mentioned claims on your behalf. YOU MUST PROVIDE A VALID WORKERS COMP/AUTO CLAIM NUMBER, an accurate claim address, phone number and case managers name. Should the required information be unavailable, payment will be due at the time of your visit. Alternately, you may reschedule your appointment. We are unable to provide treatment on a lien basis.

ACCOUNT BALANCE

- Patient statements are mailed out at the beginning of each month. Account balances are due within 30 days of receipt. Short term payment plans may be may be considered in special cases (call: 303.443.2771 to speak with a representative). We participate with the patient payment program Care Credit (to apply go to www.carecredit.com). Abandoned or delinquent accounts will be forwarded to a collection agency. There is a $45 fee for NSF checks per incident.

HIPAA (HEALTH INFORMATION PRIVACY ACT

- Boulder Valley Ear, Nose & throat Associates, P.C., adhere to the patient privacy guidelines stated in the Boulder Valley Privacy Practices document. A copy of this document is available to you upon request. You may also view a digital copy on our web site; www.bouldervalleyent.com.

MISSED APPOINTMENTS

- **KINDLY GIVE A MINIMUM OF 24 HOURS NOTICE TO RESCHEDULE OR CANCEL YOUR APPOINTMENT. FAILURE TO GIVE NOTICE WILL INCUR A $50 FEE FOR REGULAR APPOINTMENTS OR A $100 FEE FOR MISSED SURGERIES.**

Medical History Form

Patient Name: _____ **Date:** _____

DRUG ALLERGIES/REACTIONS:

Patient Medical History

☐ **No significant Medical History**

Yes ☐ Acute Myocardial Infarction (Heart Attack)
Yes ☐ Allergic rhinitis
Yes ☐ Alzheimer's Dementia
Yes ☐ Anemia
Yes ☐ Arthritis
Yes ☐ Cataract
Yes ☐ **Cancer**
Yes ☐ Breast Cancer
Yes ☐ Lung Cancer
Yes ☐ Prostate Cancer
Yes ☐ Thyroid Cancer
Yes ☐ Coronary Artery Disease
Yes ☐ Diabetes Mellitus
Yes ☐ GERD
Yes ☐ Glaucoma
Yes ☐ Gout
Yes ☐ **Hepatic Disorder**
Yes ☐ Hepatitis A
Yes ☐ Hepatitis B
Yes ☐ Hepatitis C
Yes ☐ Hearing Loss
Yes ☐ Hypercholesterolemia (High Cholesterol)
Yes ☐ HIV
Yes ☐ Hypertension (High Blood Pressure)
Yes ☐ Migraine Headache
Yes ☐ Osteoporosis
Yes ☐ Psychiatric Disorders
Yes ☐ **Respiratory Disorders**
Yes ☐ Asthma
Yes ☐ Tuberculosis
Yes ☐ COPD
Yes ☐ Seizure Disorder
Yes ☐ Sleep Apnea
Yes ☐ Stroke
Yes ☐ Thyroid Disorders

Other: _____

********Please have your medication list ready for the medical staff. Thank you!**

Medical History Form

Surgical History

☐ No Surgical History

Yes ☐ Adverse reaction to Anesthesia

Yes ☐ Easy Bruising Tendency

Yes ☐ Easy Bleeding

ENT Surgeries

Yes ☐ Tonsillectomy

Yes ☐ Adenoidectomy

Yes ☐ Thyroid Surgery

Yes ☐ Tubes

Yes ☐ Mastoidectomy

Yes ☐ Tympanoplasty

Yes ☐ Sinus Surgery

Yes ☐ Septoplasty

Yes ☐ Turbinate Reduction

Yes ☐ Polypectomy

Yes ☐ UPPP

Other _____

OTHER Surgeries

Yes ☐ Appendectomy (Appendix Surgery)

Yes ☐ Breast Surgery

Yes ☐ Cardiovascular Surgery (Heart Surgery)

Yes ☐ C-section Delivery

Yes ☐ Cholecystectomy (Gall Bladder Surgery)

Yes ☐ Hernia Repair

Yes ☐ Hysterectomy

Yes ☐ Lung Surgery

Yes ☐ Oral Surgery

Yes ☐ Orthopedic Surgery

Yes ☐ Renal Surgery (Kidney Surgery)

Other _____

Family Medical History

☐ No significant Family Medical History

Yes ☐ Anesthesia Reaction

Yes ☐ Bleeding Problems

Yes ☐ Cancer

Yes ☐ Hearing Loss

Yes ☐ Migraine Headache

Yes ☐ Thyroid Disorder

Social History

Yes ☐ Alcohol use: # _____drinks p/Week _____p/Day

Yes ☐ Tobacco use : #_____ packs a day

Yes ☐ History of smoking ___ years, year quit _____

Yes ☐ Drug use

Yes ☐ Marijuana

_____ _____

Patient Signature ***Date***

BOULDER VALLEY
Ear, Nose & Throat
Main Ph# 303.443.2771 ▪ Main Fax# 303.443.2784 ▪ www.BVENTDocs.com

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Consent Form

CONSENT TO ALLOW A FAMILY MEMBER OR OTHER AUTHORIZED PERSON ACCESS TO THE PATIENTS MEDICAL OR CHARGE/PAYMENT INFORMATION

Patients Name: _____

1) I am either the Patient identified above, or I am the personal representative of the Patient with legal authority to make health care decisions for the Patient.

2) The person(s) listed below are family members or others who are involved in the Patient's health care or payment for healthcare. I give permission to Boulder Valley Ear, Nose & Throat Assoc., PC's authorized representative, to disclose the Patient's protected health information to such persons.

[List names and phone numbers of persons]

_____

_____

_____

3) Where would you like your statements sent? ☐ Check if same as home address

Send To: _____

Relationship: ____ Spouse ____ Parent ____ Child ____ Caregiver ____ Other

Send Statements to the following Address:

_____
Street Address

_____
City *State* *Zip*

4) In addition to the persons listed above, there are or may be other persons who are involved in the Patient's health care or payment for health care. This consent is not intended to limit PROVIDER's authority to disclose protected health information to such other persons or to other entities to the extent allowed by applicable law, including but not limited to 45 CFR §§ 164.506, 164.510, and 164.512, and PROVIDER does not agree to such restriction.

_____ _____
Signature *Date*

If signed by a Personal Representative:

_____
Print name of Personal Representative

_____
State authority of Personal Representative or relationship to Patient